CHAPTER M18
MEDICAL SERVICES

M18 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-12	04/01/2019	Page 3, 5
TN #11 DMAS -11	01/01/2019	Page 3
TN #DMAS-10	10/1/18	Pages 3-5
TN #DMAS-6	10/1/17	Table of Contents Pages 3-5 Page 6 is a runover page. Page 6a was added.
TN #100	5/1/15	Table of Contents Pages 1-9 Pages 10-17 were deleted. Appendix 1 was removed.
UP #9	4/1/13	Page 3
UP #7	7/1/12	Page 12
TN #96	10/01/11	Pages 3, 4, 16
TN #95	3/1/11	Page 9
TN #94	9/1/10	Page 12
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M1810.100 MEDICAID ELIGIBILITY CARD

**A. Medicaid
Card Issuance**

A Medicaid card is issued to an individual who has been found eligible for Medicaid and is enrolled with the Department of Medical Assistance Services (DMAS). The card is plastic with the enrollee's name, gender and birth date on the front, and a strip on the back that providers can "swipe" to ascertain the type of coverage and the begin date of coverage. The card is intended to be permanent. Presentation of the card to the Medicaid-enrolled (certified) provider of medical services authorizes the provider to bill Medicaid for the needed services, if such services are covered by the Medical Assistance Program and DMAS has pre-authorized the service, when pre-authorization is required.

Exception: The following recipients do not receive a Medicaid card:

- individuals eligible for Medicare premium payment only,

- individuals enrolled in a closed period of coverage in the past with no ongoing coverage, and

- *incarcerated individuals eligible for Medicaid payment of inpatient hospitalization services only.*

**B. Use of the Medicaid
Card**

1.   General

Local social services departments must provide recipients with information concerning use of the Medicaid card. This includes information that misuse of the card is fraud and can result in prosecution. Examples of misuse include:

- using the card following cancellation of eligibility,

- alteration of names, dates, or other information to secure medical care to which the individual is not entitled, and

- knowingly permitting another person to use an individual's card to secure medical care.

**2. Foster Care
Children in
Institutional
Facilities**

The local department of social services (LDSS) should use the local department's address when enrolling a foster care child whose custody is held by the local department of social services and who is placed in an institution. Upon receipt of the Medicaid card, it should be sent to the appropriate institution for use on the child's behalf. The local department has the responsibility of advising the child caring institution of the medical and dental services covered by Medicaid.

3. Nursing Facility Patients   Patients in nursing facilities receive Medicaid cards. The nursing facility also receives a computer-generated list at the first of the month which lists all eligible Medicaid patients in that facility.

This *report* reflects only those Medicaid-eligible patients for whom the nursing facility has submitted an "admission packet."

DMAS staff enters the patient information into the system and assigns a patient control number to the facility for use in billing Medicaid for the patient's care.

When a patient dies or is discharged from the facility, the facility is responsible for notifying DMAS and the LDSS of the date of discharge or death. Long-term care (LTC) providers have been instructed to notify the LDSS of death or discharge via the Medicaid Long-term Care Communication Form (DMAS-225).

M1820.100 SERVICE PROVIDERS

A. Enrollment Requirement   Providers of medical services must be enrolled by DMAS to receive Medicaid payment for their services. Lists of enrolled providers are available to local departments of social services and enrollees from DMAS and are available online at www.dmas.virginia.gov.

B. Out-of-State Providers

1. Covered Services   Medicaid will cover medical services rendered by out-of-state providers when the use of such providers is:

a. the general custom of the eligible individual (e.g., a recipient living near the border of another state),

b. needed by a non IV-E Foster Care child placed outside Virginia,

c. necessitated when an eligible person is temporarily outside Virginia and has a medical emergency, or

d. indicated because of referral to an out-of-state facility when preauthorized by DMAS.

2. Provider Enrollment   In instances where an out-of-state provider is not currently enrolled as a DMAS provider, DMAS will accept the provider's initial billing and will contact the provider to determine the provider's wish to become enrolled so that subsequent services can be paid through the computerized Medicaid claims processing system.

M1830.100 MANAGED CARE

A. General Information

DMAS provides Medicaid coverage to enrollees primarily through two delivery systems: fee-for-service (FFS) and managed care. FFS benefits are administered by DMAS through participating providers within the traditional Medicaid program rules. Most Virginia Medicaid enrollees *including individuals with other forms of health insurance (TPL)* are required to receive medical care through a managed care organization.

B. *Medallion Programs*

The Medallion 4.0 managed care program is administered through DMAS' contracted managed care organizations (MCO).

Individuals eligible for Medallion *4.0* include non-institutionalized enrollees in both Families & Children (F&C) and Aged, Blind or Disabled (ABD) covered groups. Some enrollees in the groups below are not Medallion *4.0* eligible because they meet exclusionary criteria. The following is a **partial** list of enrollees excluded from managed care enrollment:

- Enrollees who are inpatients in state mental hospitals,
- Enrollees who are in long-stay hospitals, nursing facilities, or intermediate care facilities for the intellectually disabled,
- Enrollees who meet a spenddown and are enrolled for a closed period of coverage,
- Enrollees who are participating in Plan First,
- Enrollees under age 21 in Level C residential facilities,
- Enrollees who have an eligibility period that is less than three months or who have an eligibility period that is only retroactive.

All Medallion 4.0 health plans offer enhanced benefits to members including, but not limited to:
- Adult Dental
- Vision for adults
- Cell phone
- Centering pregnancy program
- GED for Foster Care
- Sports physical at no cost (under age 21)
- Swimming lessons for members six (6) years and younger
- Boys and Girls Club membership (6-18 olds)
- Free meal delivery after inpatient hospital stays

Note: Not all health plans will offer all of the same enhanced benefits

Enrollees excluded from mandatory managed care enrollment shall receive Medicaid services under the current fee-for-service system. When enrollees no longer meet the criteria for exclusion, they shall be required to enroll in the appropriate managed care program.

Enrollees and their families may contact the Medallion 4.0 Helpline at 1-800-643-2273 for information and assistance.

C. Managed Care HelpLine

Eligible individuals can enroll in an MCO or obtain additional information, as well as assistance with coverage issues, by calling the Managed Care HelpLine at 1-800-643-2273 (TTY/TDD 1-800-817-6608). The Helpline is available Monday through Friday from 8:30 a.m. until 6:00 p.m. Information is available online at www.virginiamanagedcare.com.

D. Family Access to Medical Insurance Security Plan (FAMIS) Managed Care

FAMIS benefits are administered through DMAS contracted MCOs or through FAMIS fee-for-service. The DMAS contracted MCOs for FAMIS are the same as those contracted with DMAS for Medallion 3.0.

In all areas of the Commonwealth, FAMIS enrollees have the choice between 2 or more MCOs. When a child is first enrolled in FAMIS, he or she is able to access health care through the FAMIS fee-for-service program. Within 1 or 2 months after FAMIS enrollment, the child will be enrolled with a FAMIS MCO.

FAMIS benefits are slightly different than the benefits that children enrolled in Medicaid receive. There are benefit limitations and small co-payments similar to those associated with commercial group health insurance. The following is a partial list of services (while covered under Medicaid) are **NOT** covered under FAMIS.

- Early and Period Screening Diagnosis and Treatment (EPSDT) services are not covered for FAMIS MCO members. Many of the services that are covered as EPSDT services by Medicaid are covered under FAMIS MCO's well child and immunization benefits. EPSDT services **are** covered for FAMIS FFS members because they receive the Medicaid benefit package.

- Psychiatric treatment in free standing facilities is not covered under FAMIS. However, psychiatric treatment is covered when provided in a psychiatric unit of an acute hospital.

- Routine transportation to and from medical appointments is not covered for FAMIS MCO enrollees. Children enrolled in FAMIS FFS may receive non-emergency transportation services. Emergency transportation is covered for both FAMIS MCO and FAMIS FFS enrollees.

- Intensive in-home, therapeutic day treatment, mental health crisis intervention, and case management for children at risk of or experiencing a serious emotional disturbance are covered under FAMIS. Other community mental health rehabilitation services are not covered.

Eligible FAMIS individuals can enroll in an MCO or obtain additional information, as well as assistance with coverage issues, by calling Cover Virginia at 1-855-242-8282, Monday through Friday from 8:00 a.m. until 7:00 p.m. and Saturdays from 9:00am – noon. Information is also available online at www.covervirginia.org.

A summary of FAMIS covered services can be found online at:
http://coverva.org/mat/FAMIS%20Covered%20Services.pdf.

E. Commonwealth Coordinated Care (CCC) Plus

Effective August 1, 2017, the CCC Plus Medicaid managed care program was implemented. CCC Plus operates statewide through a network of managed care plans across six regions as a mandatory program serving adults and children with disabilities and complex care needs. Individuals in nursing facilities and the home and community based waivers, as well as dually-eligible individuals (those with both Medicare and Medicaid) receive Medicaid through CCC Plus. Individuals receiving services through the Developmental Disabilities waivers are currently enrolled in CCC Plus only for their non-waiver services.

*The following is a **partial** list of enrollees excluded from enrollment in CCC Plus:*

- *Limited covered groups – Plan First, Qualified Medicare Beneficiaries (QMB) only, Special Low income Medicare Beneficiaries (SLMB), and Qualified Individuals (QI);*

- *Enrollees in specialized settings – intermediate care facilities for individuals with intellectual disability (ICF-ID), Veterans' nursing facilities, psychiatric residential treatment facilities (PRTF), the Virginia Home, and the Piedmont, Catawba and Hancock state facilities;*

- *Enrollees in hospice care (CCC Plus who elect hospice will remain in CCC Plus);*

- *Enrollees in other programs – Medicaid or FAMIS Medallion 4.0 managed care, and the Program for All-inclusive Care for the Elderly (PACE).*

Medicaid Expansion enrollees receive the same amount, duration and scope of services as other CCC Plus Program Members, with the following four (4) additional federally-required essential health benefits.

- *Annual adult wellness exams;*
- *Individual and group smoking cessation counseling;*
- *Nutritional counseling for individuals with obesity or chronic medical diseases;*
- *Recommended adult vaccines or immunizations.*

Enrollees and their families may contact the CCC Plus Helpline at 1-844-374-9159 for information and assistance.

G. Enrollment Corrections/ Changes

DMAS pays a capitation rate for every month an individual is enrolled in managed care regardless of whether the individual receives medical services during the month. If an individual is incorrectly enrolled in a Medicaid managed care program, the eligibility worker must refer the case to DMAS at the following address for possible recovery of expenditures (see chapter M1700):

> Recipient Audit Unit
> Department of Medical Assistance Services
> 600 East Broad Street, Suite 1300
> Richmond, VA 23219

M1840.100 UTILIZATION REVIEW AND CLIENT MEDICAL MANAGEMENT

A. Utilization Review

Federal regulations require the Department of Medical Assistance Services (DMAS) to regularly review recipients' use and need for the covered medical services they receive. Regulations require that Medicaid pay only for medically necessary covered medical services. Medicaid cannot pay for duplicate services since they are not necessary.

DMAS staff in the Program Integrity Division reviews provider claims and recipient utilization histories for medical necessity. If it is determined that services were not medically necessary, providers are obligated to reimburse DMAS for any Medicaid payment they have received.

B. Client Medical Management (CMM) Program

An enrollee's utilization of Medicaid cards for physicians' services and pharmaceutical services is monitored regularly by DMAS. Whenever the utilization of one or both of these services is unusually high, the services will be reviewed for medical necessity. If some services are considered not medically necessary, recipients who are not enrolled in a managed care program will be placed in the CMM Program and required to select a primary physician and/or pharmacy or both.

Individuals identified as high utilizers will receive a letter of notification with instructions about selecting primary providers and identifying those providers to DMAS. Individuals who do not respond to the letter within the specified time will have their primary physician and pharmacy designated by DMAS.

For recipients who have been placed in the CMM Program, Medicaid payment for physicians' services will be limited to those services rendered by the primary physician (including a physician providing services to the patients of the primary physician when the primary physician is not available), physicians seen on referral from the primary physician, and emergency medical services.

Prescriptions may be filled by a non-designated pharmacy only in emergency situations when the designated pharmacy is closed or cannot readily obtain the drug.

M1850.100 COVERED SERVICES

A. General Information

Information on Medicaid covered services is provided to assist the eligibility worker in responding to general inquiries from applicants/recipients. Individuals who have problems with bills or services from providers of care should be referred as follows:

- Refer FFS Medicaid enrollees to the DMAS Recipient Helpline at 804-786-6145. Refer individuals who need assistance with transportation to the DMAS transportation broker at 1-866-386-8331.

- Refer individuals enrolled in managed care to the Managed Care HelpLine at 1-800-643-2273 or directly to their MCO. Individuals in managed care who need assistance with transportation must contact their MCO directly.

B. Copayments

a. Medicaid Enrollees without Medicare

Most Medicaid covered services have a "copayment," which is the portion of the cost of the service for which the recipient is responsible. Copayment amounts range from $1.00 to $3.00 for most services. There is a $100.00 copayment per admission for inpatient hospital stays. The provider collects the copayment directly from the enrollee at the time the service is provided.

b. Medicare Beneficiaries

Individuals with Medicare and full-benefit Medicaid (dual eligibles) and Qualified Medicare Beneficiaries (QMB) are responsible for Medicaid copayments only. Medicaid covers the remainder of the Medicare copayment for these individuals. However, a provider is allowed to collect the Medicare copayment at the time of service. If the provider requires the individual to pay the Medicare copayment, the individual must be reimbursed or credited the difference between the Medicare and Medicaid copayments once the provider receives payment of the Medicaid claim.

B. Individuals Exempt from Copayments

The following individuals are exempt from the Medicaid copayments:

- children under 21 years old,

- *pregnant women,*

- individuals who receive long-term care services in a nursing facility, rehabilitation hospital, or long-stay hospital, and

- individuals receiving Medicaid community-based care (CBC) waiver services and hospice care.

C. Services with No
    Copayments

The following services do not have copayments:

- emergency-room services,

- pregnancy-related services,

- family planning services, and

- dialysis services.

D. Covered Services

The services listed below are covered:

- case management services;

- certified pediatric nurse and family nurse practitioner services;

- clinical psychologist services;

- community-*based services for individuals with intellectual disabilities*, including day health rehabilitation services and case management;

- dental services for individuals under age 21 years *and pregnant women;*

- emergency hospital services;

- Early Periodic Screening, Diagnostic and Treatment (EPSDT) services;

- family planning services;

- Federally Qualified Health Center clinic services;

- home and community-based care waiver services (see subchapter M1440);

- home health services: nurse, aide, supplies, treatment, physical therapy, occupational therapy, and speech therapy services;

- hospice services;

- inpatient hospital services;

- *Intensive Behavioral Dietary Counseling*, *for individuals in MEDICAID WORKS*;

- intermediate care facility services *for the intellectually disabled (ICF-ID)*;

- laboratory and x-ray services;

- Medicare premiums: Hospital Insurance (Part A); Supplemental Medical Insurance (Part B) for the Categorically Needy (CN) and Medically Needy (MN);

- mental health services, including clinic services, case management, psychosocial rehabilitation, day treatment/partial hospitalization, therapeutic day treatment for children and adolescents, intensive in-home services for children and adolescents, and crisis intervention services;

- nurse-midwife services;

- nursing facility care;

- other clinic services: services provided by rehabilitation agencies, ambulatory surgical centers, renal dialysis clinics, and local health departments;

- outpatient hospital services;

- *personal assistance services, for individuals in MEDICAID WORKS*;

- physical therapy and related services;

- physician services;

- podiatrist services;

- prescribed drugs;

- prosthetic devices;

- Rural Health Clinic services;

- skilled nursing facility services for individuals under age 21 years;

- substance abuse services;

- transplant services;

- transportation to receive medical services; and

- vision services.

M1860.100 SERVICES RECEIVED OUTSIDE VIRGINIA

A. General

Medicaid must pay for covered medical services received by any eligible person who is temporarily absent from Virginia if the medical service provider agrees to accept Medicaid payment.

B. Out-of-State Institutional Placements

Virginia Medicaid will cover an *enrollee* who is placed in *an LTC* facility in another state only if the placement is preauthorized by the DMAS Long Term Care Section.

A child in IV-E Foster Care who is placed in an institution outside Virginia is eligible for Medicaid through the state in which he resides. A child in non-IV-E Foster Care is eligible for Virginia Medicaid when the child is in an institution outside Virginia, since the child is considered to be a resident of the locality which holds custody.